Memorial Hermann Health System
Outpatient Paracentesis Referral Order

Date: _____

Patient Name: _____ DOB: _____

Patient Diagnosis: _____

Primary Care Physician: _____

PCP Clinic Phone Number: _____

Outpatient Paracentesis Order: _____

Start Date: _____ End Date: _____

Frequency: Every 7-14 days or as determined by Interventional Radiologist

_____

_____

_____

_____

_____

_____

☐ I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

_____	_____	_____	_____	_____ ☐ AM ☐ PM	_____
Provider Signature	**Print Name**	**NPI/MHHS ID.**	**Date**	**Time**	**Contact No.**

☐ Memorial Hermann Greater Heights
1635 North Loop West
Houston, Texas 77008

☐ Memorial Hermann Southwest
7600 Beechnut Street
Houston, Texas 77074

MEMORIAL HERMANN

Outpatient Paracentesis
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